Health Sciences
Perdue Hall
800 College Court
New Bern, NC 28562
252-639-2025
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PTA Program Observation Hours Verification Form

The Physical Therapy Assistant (PTA) Program at Craven Community College requires applicants to obtain at least 16 hours of observation in ***two*** separate settings (8 hours in each setting), as a volunteer, with a licensed Physical Therapist or PTA, within 12 months of the application date. Students **must** maintain professional dress, behavior, and communication during observation hours. Failure to do so may result in removal from the site and loss of hours.

Upon completing this form, the PT/PTA that was observed must place it in a sealed envelope with their signature across the seal. Applicant is to return the sealed envelope to the: **Arianne Murray, Admissions & Advising Coordinator – Health Programs, 800 College Court, Perdue Hall Room 101G, New Bern, NC 28562*, no later than May 31st.***

Following observation, the applicant is to write a 250 - 500 word reflection discussing the interaction between the PTA/ PT and the patients they were treating. What treatments did you observe? Did you observe any alterations in treatment from one patient to another? How did you feel when you saw a positive interaction between the clinician and a patient? Once your reflection is complete, place it in a separate envelope from the signed verification form envelope. Submit the two envelopes together prior to the deadline. **Forms *must* be received by Health Programs no later than May 31st.**

Applicant Name: _____ **Student ID #:**_____
Email:_____ **Applicant Phone #:**_____

Name of Facility: _____
Address of Facility: _____
City: _____ State: _____ Zip code: _____
Phone # of Facility: _____
Name of clinician observed: _____
Credentials of clinician observed: _____
State and license # (to be kept confidential): _____
Email: _____

PT setting where observation occurred (choose *TWO different settings*):

____ Acute Care
____ Rehab/Sub Acute Rehab
____ Extended Care Facility/Nursing Home
____ Skilled Nursing Facility
____ Home Health
____ Outpatient Clinic (Private Practice)
____ School/Pre-School
____ Wellness/Prevention/Fitness
____ Industrial/Occupational Health
____ Other (please specify): _____

Dates and times of observation:

Date: _____ Time in: _____ Time out: _____
Date: _____ Time in: _____ Time out: _____
Date: _____ Time in: _____ Time out: _____
Date: _____ Time in: _____ Time out: _____

_____ _____
Signature of Licensed PT/PTA **Date**

Updated 12.4.2025